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A study of occupational therapy and case management in mental health

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A STUDY OF OCCUPATIONAL THERAPY AND CASE MANAGEMENT IN MENTAL HEALTH

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ABSTRACT

The purpose of this study was to identify services provided by occupational therapists in mental health to determine if similarities could be identified between occupational therapy and case management functions. In addition, the attitudes and perceptions that occupational therapists had about case management were surveyed.

The results indicated a majority of occupational therapists who work in mental health in California perform case management functions to some degree. The data indicated that a majority (83%) of occupational therapists would consider an occupational therapist as capable of fulfilling the professional role of a case manager.

As a result of the findings in this study, the relationship of case management models in the literature and occupational therapy practice in mental health were discussed. Recommendations were made for further research, and the professional implications in the field of occupational therapy were discussed.

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INTRODUCTION

Purpose

The purpose of this study was twofold: 1) to determine the attitudes of psychiatric occupational therapists (OTRs) who are working with chronically mentally ill (CMI) populations concerning case management and 2) to determine whether any identifiable services offered by OTRs fulfill case management functions.

Statement of the Problem

In the 1960s after legislative changes in the mental health system, community mental health centers had the enormous task of reintegrating and meeting the needs of individuals from state and county hospitals, who suffer from chronic mental illness, into the community. Comprehensive, integrative services required to manage the CMI population that reside in the community are not being provided by the community mental health system. Statistics that may be indicative of the effectiveness of community mental health programs show that as many

as 40% of the homeless persons in cities suffer from a major mental illness (Lamb & Talbot, 1986).

The challenge is to deliver effective services to this population so that they are able to survive in the communities in which they reside. Many individuals who are chronically mentally ill are not adequately treated and are often neglected in the community setting. The cohesive structure and continuity of the holistic approach of case management practices has been shown to be beneficial to the CMI population. There is an indication that services currently provided by psychiatric OTRs, working with CMI populations, are those of a case manager.

Case management provides continuity to the community mental health system because of the coordinated, comprehensive and integrated service it offers to meet the needs of the CMI. In order for individuals to meet medical, financial, social, vocational, or recreational needs in the community, they must visit a variety of state, local or private agencies for service. The maze of services require an assertive concentrated effort by the individual to be successful. The very nature of chronic mental illness presents clients who have low motivation and passivity which interferes with or

prevents them from seeking and using community services. Case management involves one-to-one coordination or a team approach of services for each individual client to enhance his/her quality of life and survival in the community system. A case manager using this approach continuously assesses and monitors the client's skills to survive in the community. The role may include direct provision of services, linking the individual to other services, advocacy on the client's behalf, liaison between client and significant other parties, and support and long-term follow-up with the client. Case management in community mental health offers an essential service because there is potential to overcome the complexity and fragmentation of the current system which is inadequately serving the CMI population.

Although case management is beginning to be accepted as an effective way to integrate mental health services for the CMI, the mental health profession most qualified to fulfill case management principles is not clear. Currently many mental health practitioners act as case managers and their professional and educational level may vary considerably. If the case management model stresses continuity and consistency for ensured delivery of quality services, then it is imperative that the role of

case manager be identified and qualified to ensure the integrity of the program. This research investigated whether occupational therapists could, and currently do, fulfill the role of case manager.

Objectives

The objectives of this study were to:

1. Determine the number of occupational therapists who are working as case managers with the chronically mentally ill in California.
2. Determine the attitudes held by occupational therapists who are working as case managers in California concerning the role of case management.
3. Identify services currently offered by occupational therapists that are recognizable as case management functions.
4. Contribute to a model of case management for occupational therapy.

Questions

The research questions generated for this study were:

1. How many occupational therapists who practice in community mental health settings with the chronically mentally ill populations perform the functions of case managers?

2. Do occupational therapists in community mental health settings perform case management functions and perceive themselves as potential case managers?

3. What services are occupational therpists, who work in community mental health with chronically mentally ill populations, currently offering that are recognizable as case management functions?

4. Does the model of case management, as described in the literature, correspond to the functions performed by occupational therapists who are currently working in community mental health?

Definitions

Case management - a method to provide coordination of service delivery for chronically mentally ill in the community mental health system (Intagliata, 1982).

Case manager - the individual who monitors needs and provides services to chronically mentally ill populations so that they can function as independently as possible in the least restrictive environment in the community (Intagliata, 1982).

Case management functions - specific job responsibilities a case manager fulfills to monitor needs and provide the service of case management to individuals who are

chronically mentally ill.

Chronically mentally ill - psychiatric patients with the presence of a diagnosis of at least six months that interferes with independent functioning of life roles in community living (Test & Stein, 1978).

Community mental health - a mental health service located in the community, meeting and treating the mental health needs of the residents in the community.

Model of case management - a model of treatment to provide services to individuals who are chronically mentally ill in a comprehensive and cohesive manner to meet client's basic needs to live in the community.

Occupational therapist - a registered therapist whose practice involves treatment of individuals who have an illness or disability which interferes with their daily functioning.

Assumptions

The assumptions held by the researcher were:

1. Occupational therapists may be currently fulfilling some roles of case management, but have not formally identified case management as a treatment or intervention approach.

2. California is similar to and may be representative of the rest of the United States in mental health service delivery and the current problems that plague the system.

Limitations

One limitation of this study was the population from which the sample was drawn. Data were collected only from registered occupational therapists in California who were then members of the Occupational Therapy Association of California. This population was comprised of a high number of OTRs who practice in acute care settings as compared to day treatment or community settings.

Every effort was made to make the questionnaire clear; however, because it was self-administered, the questions were subject to individual interpretation by each respondent. The information collected was dependent on the accuracy of individual interpretation.

Significance of the Study

The CMI populations are in need of immediate attention from the mental health system. The combination of deinstitutionalization and the inadequacies of the community mental system leave many

CMI individuals living an impoverished, minimal existence in the community. Many CMI end up in jails or are homeless on the streets (Gralnick, 1985). Case management is a viable option for the coordination of services for the long-term mentally ill because it addresses the needs of CMI populations and attempts to ensure a better quality of life for these individuals in the community.

However, instead of one mental health profession performing the services necessary for case management, many mental health practitioners currently fulfill this role. This raises the question whether case management is being effectively administered to all CMI populations. The criteria for case management and services rendered currently by occupational therapists (OTs) in mental health with CMI appear to have parallels; however, no distinct connections can be made without further exploration.

As mental health professionals, and as part of society, there is an obligation to attempt to develop methods to best serve the CMI population. OTRs working in the mental health system have the opportunity and obligation to provide a valuable component of the services to solve the current dilemma of the community

mental health system. The importance of this study was to identify the contribution currently being made by occupational therapists in the community mental health system and the perceived effectiveness of the approach of case management for the CMI populations in the community. There are indications that OTs may already be fulfilling some functions of case management, but no research currently exists. Information gathered will help to substantiate or refute the appropriateness of the case management model for occupational therapy.

CHAPTER 2

LITERATURE REVIEW

This literature review covers the recent changes in the mental health system that have affected services and treatment for the population of individuals with chronic mental illnesses, the community mental health system, the case management model, and occupational therapy philosophy. Parallels between occupational therapy and the case management system have been identified.

Changes in the Mental Health System

In the last 20 years there has been a dramatic shift in the mental health system away from state institutions to community treatment centers. Greene (1984) reported that in 1955, 49% of mentally ill patients were in state and county hospitals and 23% in outpatient services (community mental health centers were not listed). Twenty years later in 1977, 9% were in state and county hospitals, 44% in outpatient services, and 33% in community mental health centers. In the late 1950s and early 1960s a national reform movement in mental health began, which was called "deinstitutionalization."

Talbott (1980) defined deinstitutionalization as the movement of discharge from hospitals into community settings, greatly reducing the patient populations requiring custodial care in government hospitals. The purpose of deinstitutionalization was to change physically isolated treatment settings in hospitals to community-based treatment for patients, under the assumption that services would be both more humane and therapeutic and more accessible. Unfortunately, the passage from the hospitals to the community was not without problems and some individuals were "lost" in the transition and received no treatment at all.

In the early 1960s, the country was involved in all forms of social reform, with strong emphasis on aiding the individual and insuring the civil rights of every person. In 1963, under the leadership of President Kennedy, a "bold new approach" in psychiatric care was adopted in the hope that greater access to the mental health system would be achieved. Bachrach (1983) described deinstitutionalization as ". . . like other civil rights protests it is ideologically committed to improving the lot of persons who are seen as helpless in gaining access to life's entitlements" (p. 14).

Another contribution to the enthusiasm and optimism

in the 1950s and 1960s in mental health care was the discovery of psychotropic medication which began to improve the possibility of treatment for patients who were previously thought to be untreatable. Morrissey and Goldman (1984) identified the use of medication and new techniques in therapy as hastening the enactment of deinstitutionalization. The issue began to surface regarding the best location for the treatment of the CMI patient. One argument called for continuation of services at state mental hospitals, while the other called for the replacement of state institutions with a community based and community controlled mental health system. However, both sides agreed that funding from the federal government was required. The federal lawmakers agreed with the community mental health services and the process of deinstitutionalization began (Morrissey & Goldman, 1984).

After more than 20 years, deinstitutionalization must be called controversial, because mentally ill patients are still not receiving quality care. Whitmer (1980) cited California's progressive mental health laws as responsible for moving mentally ill patients from the hospitals into the criminal justice system. In 1982, Lamb reported a study in which psychiatric evaluations

were performed once a week on 102 male inmates at the Los Angles County Central Men's Jail in the Forensic Mental Health Unit. Results showed 90% had a history of psychiatric hospitalizations, 92% had a prior arrest record, 76% met the criteria for involuntary hopitalization (danger to self, others or gravely disabled), 80% were diagnosed as schizophrenic, and 80% exhibited severe overt major psychopathology. The increase of criminal prosecution of the CMI patient is symptomatic of their disease process and more importantly questions the effectiveness of the community mental health system.

Community Mental Health System

Literature indicates that community mental health treatment for the CMI patient can be successful (Mendota Mental Health Institute, 1974). Test and Stein (1978) compiled a research overview of community treatment of the chronic patient and found evidence for many successful treatment programs. However, many community mental health systems have serious problems that outweigh the positive gains. Problems relate to inadequate funding, lack of integrated programs, and the specific needs of the CMI patient not being addressed.

Morrissey and Goldman (1984) discussed the economic

problems resulting from deinstitutionalization and the development of the community mental health system. They concluded that annual decreases in federal contributions forced centers to abandon poorer patients in favor of insured patients, and funding came through by way of federal-to-local community grants avoiding state involvement. This meant virtually no coordination between community and state agencies as depopulation from state hospitals occurred.

Lamb and Talbott (1986) argued that the process of deinstitutionalization was poorly implemented and that adequate, integrated community programs are lacking. They identify necessary resources in the community system as ". . . adequate number and range of community residential housing with varying degrees of supervision and structure . . . a system of follow up monitoring and responsibility for ensuring that services are provided to those who are unable to obtain them" (p. 499).

Langsley and Barter (1983) viewed the community mental health system as falling short of expected dreams of the 1960s because treatment in these centers have an emphasis on counseling and crisis intervention while the needs of the CMI populations have not been addressed. Talbott

(1980) stated that the needs of the chronic populations exceed the acutely mentally ill patients because the CMI patients require services addressing everyday living skills. Test and Stein (1978) outlined the specific needs of the CMI patient that must be addressed in order for treatment to be effective in the community. These include awareness of these patient's high vulnerability to stress, deficiencies in coping skills, extreme dependency, difficulty working in competitive job markets and problems with interpersonal relationships.

The literature questions whether the needs of the CMI population can be met in community settings. However, Reynolds and Hoult (1984) described a study exploring community treatment effectiveness versus standard psychiatric hospital in terms of the burden which is often shifted onto patient families. Their results showed that: a) relatives of the patients considered the community programs to be more satisfactory in terms of treatment, comprehensive care, and 24-hour availability of staff and b) standard hospital care costs were 26% higher than those for the community treatment programs.

Case Management with the CMI Population

Deinstitutionalization resulted in greater numbers of CMI patients living in the community, but the community

mental health system has had difficulty providing required integrative services to the CMI population. In recent years, case management has gained popularity among mental health professionals, because it offers the opportunity to improve service delivery to CMI clients. Lamb and Talbott (1986) discussed recommendations for the care of CMI in the community and identified case management as a viable option to solve the dilemma of treatment for this population. By defining a system of treatment in which case managers follow individual clients for assessment, treatment plan formulation, and continuous monitoring; community agencies can begin to accept the responsibility of service for CMI created by deinstitutionalization.

Talbott (1980) argued that case management can help direct CMI individuals through the multitude of services available in the mental health system. Schwartz, Goldman, and Churgin (1982) analyzed case management services and found that their successes were directly related to the ability to integrate the system of services that benefit the severely disordered client. They caution that case management will not solve all of the problems in mental health services for CMI populations, but it can be a way to break through the barriers and achieve effective communication among

components of the system.

The CMI population typically has low motivation and extreme passivity that interfere with the process of their seeking available services. Reported in the literature by several researchers is the proposal that individual case managers can possibly provide the connection and coordination of services between the CMI client and the mental health system. Berzon and Lowenstein (1984) described the success of a case management model in Rockland County, New York, where case managers provide a coordination of services to young adult clients with CMI who characterstically act out, resist treatment, and tend to "self-medicate" with alcohol and other substances. Perlman, Melnick and Kentera (1985) conducted a retrospective study in 1983 of 48 case records, 12 from each different case manager's caseload. They were assessing the effectiveness of a case management program in the areas of housing, financial assistance, medical benefits and psychosocial (including out-patient therapy, social, vocational/rehabilitation, and recreational areas) services. Results indicated that successes linking clients to services were 73% in housing, 85% in financial assistance, 100% in medical benefits, and 89% in

psychosocial services. The authors concluded that case management programs can be effective in helping clients connect and use services when the services are available in the community.

Another study (Wasylenki, Goering, Lancee, Ballantyne, & Farakas, 1985) compared 92 patients in a community-based rehabilitation program staffed by a psychiatric nurse, two occupational therapists, one social worker, and four non-credentialed staff with a control group of 92 patients whose psychiatric aftercare was arranged by inpatient hospital staff. The authors found that those patients in the community rehabilitation program had their needs identified better, with more comprehensive assessment, and greater access to services in the community. One point to be noted from this study was the importance of continual contact on the part of the staff. Baker and Weiss (1984) conducted a study of 30 clients and 15 case managers to identify contributions of the case management system. The results indicated the importance of case management in helping the clients to manage their daily lives. One example from the study, described how a case manager helped resolve problems in a living situation for a client that could have led to return to a mental hospital. Other instances cited

included interceding on the client's behalf with a utility company, arranging for medical attention or helping the client deal with the Social Security office. The case managers were able to recognize developing problems, intercede, and limit the consequences for their clients to reduce stresses of everyday life.

Lamb (1982) stated that case managers should not be mere "brokers of services," but should have a primary therapeutic relationship with the client. The author described this aspect as a necessary part of case management because the therapist is best able to assess the clients' strengths, capabilities, and needs and develop a supportive, trusting and encouraging relationship. Test and Stein (1978) suggested that in order to treat the CMI patient in the community, intervention must be direct, comprehensive and involve activities that focus on skills needed for daily living in the community. Case management can be a possible way to achieve these goals (Stein & Test, 1982).

However, for a system to provide congruency and consistency of service to CMI populations, a great deal needs to be done to specify or identify the qualified mental health professionals who should fill the role of case manager to provide uniform delivery of services.

Research in this area is limited, but with the growing popularity of the case management system many issues and concerns have begun to surface in the literature.

Case management is not a new approach to treat the CMI. In the past it has been connected with the profession of social work. Rapp and Chamberlain (1985) explained how the term "case management" is related to the role of "caseworker," originally developed in the early 1940s within the social work profession. The authors emphasize that the term case management today has become a vague catchall term for the numerous activities case managers fulfill, and has little resemblance to the original concept. Although case management is the treatment of choice for chronic populations, the President's Commission on Mental Health concluded that there are crises in the communities where case management is being used (Miller, 1983). Flynn (1983) further cautioned against "jumping on the bandwagon" in viewing case management as the cure-all to recent problems in community mental health and raised important questions about the lack of case management definitions. Primarily, Flynn asks who should receive services, who should dispense the services, and what will they cost?

Models of case management can best be conceptualized on a continuum; at one end there is the primary therapist with responsibility of direct treatment as well as other case management functions; and on the other end there is the case manager who has little contact with the client and is merely a "broker of services." Schwartz, Goldman and Churgin (1982) in explaining models and dimensions of case management described the success of case managers in terms of their ability to integrate the system of services for the client.

Rapp and Chamberlain (1985) presented an exploratory study of case management impact and intervention which used social work students as case managers. By their definition, the case managers in their study fell between the role of a primary therapist and a "broker of services." The focus of intervention for the CMI population in the study was on employment, education, housing, recreation and leisure time, health and family suppports. Most of the intervention took place in the client's home and local community. The authors acknowledge positive results based on response from individual clients regarding their case managers and response from referral sources. They concluded only that there is a great need to further explore types of case

management intervention.

Occupational Therapy and Case Management

The success of case management with the CMI populations involves emphasis on helping clients manage their daily lives in a complex human service system. The philosophical orientation of occupational therapy involves the use of purposeful activities that are goal-oriented and meaningful to the client, promote learning, adaptation, and change for optimal independent functioning. Evans (1985) described the role of occupational therapy in mental health as facilitating the development of interpersonal relationships and the promotion of a balance between work, play/leisure and daily living skills. The intervention is viewed as revolving around the examination of the various life roles that an individual must assume to adapt to community living and the identification and remediation of skills to support those roles (Laukaran, 1978). Emphasis is on the ability of the client to cope with the community and life changes. The OTRs role is to facilitate independence. Fine (1983) identified the primary concern of OTRs in mental health as the promotion of skills and relevant behaviors which are necessary for adequate role performance in a given environment.

Taira (1985) recognized case management as a successful approach with clients who require long term care and suggested that OTRs are ideally suited to fulfill the task of conducting the type of comprehensive functional assessment which case management requires to ensure effective treatment. Klasson and MacRae (1985) described a clinic established at San Jose State University, in San Jose, California that has a twofold purpose: 1) to provide training for occupational therapy students, and 2) to provide treatment for persons who have chronic schizophrenia. The students, with faculty supervision, were often the sole providers of services to their clients and acted in the role of case manager. The positive response to the clinic from the community, the clients, and the students suggested that occupational therapy may have a place in case management with the CMI population. Klasson (1986) proposed a model of case management in which OTRs assist CMI clients with the management of their daily lives. The case management model proposed as a result of Klasson's research would utilize OTRs in direct service delivery to clients working towards the "prevention of crisis through the mastery of community living" (p. 155). No other literature specifically combining occupational therapy

and case management has been found.

Summary

In summary, literature indicates that case management is an effective way to treat CMI populations. It has been described as being the "essential" service in community mental health because it has the potential to overcome the complexity and fragmentation of the present system. A case manager title is said to be synonymous with such names as the facilitator, linker, supporter, broker, monitor, bridger, catalyst and advocate (Sanborn, 1983). Case management functions include, "assessing the client's needs, development of a comprehensive service plan, arranging services to be delivered, monitoring and assessing the services delivered, evaluation and follow up" (Intagliata, 1982 p. 658).

Literature indicates that a major factor in the current plight of the CMI population has been the enactment of deinstitutionalization. The basic foundation of deinstitutionalization for better treatment and services was based on good intentions, but poor operational planning, implementation, and coordination between agencies has resulted in serious deficits in the community mental health system that must be addressed. Failures in the community mental health system have

exacerbated the problems of the CMI population by inadequately dealing with its needs. Recent successful intervention with this population has been seen with the case management approach, because it effectively deals with the needs of the CMI. Popularity and demand for the case management system has resulted in increased numbers of mental health practitioners fulfilling the role. This has also had an effect on the way that case management is administered. Literature indicated that there is a need to identify and define the case management system to ensure quality and uniform delivery of service to the client. Literature in occupational therapy journals has shown that its basic philosophy is congruent with the case management approach and may offer many effective services to the system. However, the specific delineation of the services which occupational therapists could contribute or are already contributing to case management has not been documented.

CHAPTER 3

DESIGN AND METHODOLOGY

Design of the Study

This was a descriptive study which used a cross-sectional survey to collect data to describe the current status of OTRs in case management in mental health practice. The method for data collection was a self-administered questionnaire. This methodology was chosen for feasibility and cost effectiveness (Babbie, 1979; Mann, 1985).

Objectives

The objectives of this study were to: 1) determine the numbers of occupational therapists who are working as case managers with the chronically mentally ill in California; 2) determine the attitudes held by occupational therapists who are working as case managers in California concerning the role of case management; 3) identify services currently offered by occupational therapists that are recognizable as case management functions, and 4) contribute to a model of case management for occupational therapy.

Research Questions

The research questions in this study were:

1) How many occupational therapists who practice in mental health settings with chronically mentally ill populations perform the functions of case managers?

2) Do occupational therapists in community mental health settings perform case management functions and perceive themselves as potential case managers?

3) What services are occupational therapists who work in community mental health with the chronically mentally ill populations currently offering that are recognizable as case management functions?

4) Does the model of case management, as described in the literature, correspond to the functions performed by occupational therapists who are currently working in commmunity mental health?

Subjects and Method of Selection

The sample for this study was limited to 225 registered occupational therapists (OTRs) working or having recently worked in mental health with the CMI population in California. A list of OTRs who were working in the mental health area was obtained from the 1987-88 directory of the Occupational Therapy Association of California (OTAC). This is a state organization of

occupational therapists active in political issues concerning health care and occupational therapy. It provides continuing education for therapists and an opportunity for networking across the state. The sample was selected by including all OTRs who were listed in the directory as working in mental health.

Data Collection

A 22 item questionnaire (Appendix A) was developed by the author to explore the perceptions of OTRs regarding case management as a practice methodology. The variables were selected from the criteria described in the literature about case management and case manager functions (Intagliata, 1982; Klasson, 1986). A statistician was consulted regarding questionnaire construction as well.

The questionnaire was composed of closed ended questions with space allowed for comments in some sections (Appendix A). Questions 1 through 3 asked demographic information concerning years of experience, position held, and hours worked. Questions 4, 5, 6, and 7 identified the practice setting, the client case load, and the percentage of CMI clients the respondents had on their case load. Questions 8 and 9 asked information on length of treatment and times per

week that clients were seen to evaluate the extent of services offered. Questions 10 through 20 (excluding number 15) asked about the specific intervention with clients to the identify functions that OTRs fulfill with the CMI populations. Question 15 asked OTRs to rank order their primary focus area in treatment with the CMI. The final questions, 21 and 22, solicited information on opinions that OTRs have about case management and whether the case manager role existed at their facility.

A pilot study was conducted on a small sample of senior students in the Program in Occupational Therapy at San Jose University. The purpose of the pilot study was to obtain reaction to the questionnaire in terms of clarity and validity. The pilot study looked at whether the questions were understandable and readable (clarity) and whether the questions solicited the information that the author intended (validity). Based on feedback received from the pilot study, revisions of the questionnaire involved elimination of counting lines that had been placed at the right margin to aid in computing responses. Comments received from a number of students indicated these lines were confusing and interrupted the flow of responding to the questionnaire. Students were also asked to record the time required to finish the

questionnaire to ensure that 20 minutes was adequate for completion. All were able to answer the questionnaire within this time frame.

Questionnaires were sent to each OTR identified as working in mental health according to 1987-88 OTAC directory. A two week deadline for response was set. A cover letter (Appendix B) accompanied each questionnaire which explained the study and a stamped return envelope was included. A reminder post card (Appendix C) was sent at the end of the two week deadline.

Data analysis was completed using Microcomputer Statistical Program, a statistical software package developed by Michigan State University (1985). The statistical computations used were descriptive, including measures of central tendency (mean), measures of variablity (percentages and standard deviations), frequency of response and goodness of fit (chi square).

CHAPTER 4

DATA AND RESULTS

The Occupational Therapy Association of California Directory for 1987 listed 225 OTRs currently working in mental health in California. Questionnaires were sent to all 225 listed and 143 questionnaires were returned for a response rate of 64%. However, of the 143 returned, eleven were undeliverable and ten respondents chose not to answer the questionnaire due to retirement or change of employment. The adjusted sample size was 204 with 122 respondents for a response rate of 60%. The data presented were computed from the 122 questionnaires. It should by noted that not all respondents answered every question; therefore, the number of responses for each question varies and is noted by (N) for size when applicable.

Demographic Data

Of the 122 OTRs who responded to the questionnaire, 51 (42%) have been working as OTRs in mental health for

ten years or more, 27 (22%) for 1-3 years, 22 (18%) for 7-9 years, and 21 (17%) for 4-6 years. The OTRs who responded were almost evenly divided between those holding positions of supervisor/senior occupational therapist (49 or 40%) and staff occupational therapist (48 or 39%). Twenty-two (18%) chose the "other" category which included answers of counselor, director of department, activity therapist, and rehabilitation liaison. The majority of OTRs who responded, 97 of the 122 (80%) held fulltime positions or per diem positions (13 or 11%). (See Table 1).

Setting and Population Data

The general information regarding types of treatment settings, current client loads, and number of clients treated per year is displayed in Table 2. Acute care hospitals were the most frequently represented as a work setting (81 or 66%) with the second highest number of therapists involved in the day treatment (31 or 25%) setting. Eighty or sixty-eight percent have a current case load of 16 or more clients. Seventy or sixty percent treat more than 150 clients per year.

In Table 3, types of settings are contrasted to percentage considered CMI. Seventy-one (56%) of the respondents considered over half of their client

Table 1

Demographic Data of OTRs in Mental Health

Years experience	N = 121	No. (%)
1 - 3 years		22 (18)
4 - 6		21 (17)
7 - 9		22 (18)
10 +		51 (42)
Position	**N = 122**	
Supervisor/Senior OTR		49 (40)
Staff OTR		48 (39)
Other*		22 (18)
Consultants		3 (2)
Employment	**N = 121**	
Fulltime		97 (80)
Other**		13 (11)
1/2 time		7 (6)
3/4 time		4 (3)

*Other response included counselor, director of department, activity therapist, and rehabilitation liaison.
**Other response included per diem positions.

Table 2

Treatment Setting and Current Case Loads of OTRs in Mental Health

Treatment Setting	N = 122	No. (%)
Acute		81 (66)
Day Treatment		31 (25)
Other *		4 (3)
Long Term		4 (3)
Community		2 (2)
Current Client Case Load	**N = 118**	
0 - 5 Clients		6 (5)
6 - 10		10 (8)
11 - 15		22 (19)
16 - 20		29 (25)
20 +		51 (43)
Total Clients per Year	**N = 118**	
0 - 50 Clients		14 (12)
51 - 100		17 (14)
101 - 150		17 (14)
151 - 200		16 (14)
201 +		54 (46)

* Other response included forensic programs, residential programs and private facilities.

Table 3

Treatment Setting and Chronically Mentally Ill (CMI)

(N = 122)

	% CMI	
	0-50	50-100
Treatment Setting	No.(%)	No.(%)
Acute	42 (34)	39 (32)
Day Treatment	5 (4)	26 (21)
Long Term	0 (0)	4 (3)
Other *	3 (2)	1 (0)
Community	1 (0)	1 (0)
Totals	51 (40)	71 (56)

*Other included forensic programs, residential programs and private facilities

population in the category of CMI (under the definition given in the questionnaire). The 71 replies, consisted of 39 in acute care setting and 26 in day treatment setting, the other 6 falling in community, longterm or other settings.

Treatment Related Issues

Summmarized in Table 4 is the length of stay and number of times of therapy per week for each treatment setting. As expected with the highest number of respondents working in acute care settings, 62 (51%) reported length of treatment as less than one month, 20 (16%) from 1-3 months and 16 (13%) for over 12 months. If the data are combined, 87 (98%), which is most OTRs responding from acute care settings, had the higher number of responses for length of treatment under 6 months. OTRs in day treatment settings had the most responses, 24 or 77%, for length of treatment over 6 months.

In all settings, 83 or 68% of the therapists saw their clients at least five or more times a week. Therapists in day treatment settings had the most variation of services with responses ranging from two times a week to five times a week. In the acute acute settings, 88% (72 of 81) of the therapists saw their

Table 4

Length of Stay and Number of Treatment Times per Week Reported in each Treatment Setting

(N = 122)

	Treatment Setting					
	Community	Day Tx*	Acute	Longterm	Other**	Total
Length of stay						
< 1 month	0	0	61	0	1	62
1 - 3	1	2	16	0	1	20
4 - 6	0	5	1	2	2	10
7 - 9	0	4	1	1	0	6
10 - 12	0	7	0	0	0	7
12 +	1	13	1	1	0	16
Treatment per week						
1 time(s)	1	0	0	0	1	2
2	0	6	2	0	2	10
3	0	9	5	2	0	16
4	0	7	2	1	1	11
5 +	1	9	72	1	1	83

*Day Treatment setting
**Other included forensic programs, residential programs and private facilities.

clients at least five times a week or more.

Therapists were asked to rank the focus area of their practice with the CMI. The scale categories were one to eight, the primary focus of treatment (1), and the least focus of treatment (8). These results are shown in Table 5. Chi-square analysis was used for the purpose of demonstrating that it was not random chance that individuals chose cognitive skills over sensory motor for a treatment focus and that the variables were dependent on one another. The chi-square analysis indicated statistical significance in the preferences that OTRs reported in the rank order of the foci of treatment and understandable variable dependence ($\underline{X}^2$ (49, N = 122) = 415.03, $\underline{p}$ <.05. The means ($\underline{M}$) calculated within each focus treatment area, using the scale ranking of 1 (primary focus of treatment) to 8 (least area of focus of treatment), indicated that therapists generally ranked foci of treatment in the following order: (1) cognitive skills (attention, concentration, problem solving, and following directions); (2) social skills (communication and behaviors); (3) activities of daily living (cooking, cleaning, money management, time management, and transportation); (4) leisure skills (interests and

Table 5

Ranking of Focus Areas in Treatment

N = 122

Choices	Ranking* 1	2	3	4	5	6	7	8	M	SD
Cognitive skills	51	28	20	9	5	4	1	1	2.3	1.6
Social skills	39	19	25	26	5	4	1	0	2.6	1.5
Activities of Daily Living	14	24	17	16	15	17	8	5	3.9	2.0
Leisure	7	8	14	24	28	18	17	1	4.6	1.7
Self-care	7	16	14	12	19	19	17	14	4.9	2.1
Psychodynamic	11	14	10	12	11	10	10	39	5.3	2.5
Vocational	3	7	12	10	14	21	27	24	5.7	2.0
Sensory motor	2	8	6	14	13	18	28	27	5.9	1.9

Chi square 415.03 (49 df)

Significance $p < .05$

M= mean ranking over all eight foci
SD= standard deviation for eight foci

*Note: Scale of ranking 1 to 8: 1 = primary focus in treatment; 8 = least area of focus in treatment.

hobbies); (5) self-care (hygiene, grooming, and body awareness); (6) pychodynamic/psychotherapeutic activities (projective techniques, insight, and reduction of symptomology); (7) vocational areas (work tasks and skills training); and (8) sensory motor (sensory stimulation).

Identifiable Functions of Occupational Therapists

In questions number 10 through 20 of the questionnaire, OTRs were asked to identify areas of treatment which they currently were able to incorporate into their practice with their CMI clients. These questions were asked to determine what services occupational therapists, who are working with chronically mentally ill populations, currently offer that are recognizable as case management functions. Also, the questions were to determine how many occupational therapists who practice in community mental health settings with this population perform the functions of case managers. Twenty functions were given. Of these twenty, ten were keyed as functions considered under case management. In Table 6 the first ten identifiable functions most commonly performed by OTRs in practice are shown. Frequency rate shows a high

Table 6

Identifiable Functions Performed by OTRs

Functions	(N)	No. (%) yes	no
Initial Interview	122	107(88)	15(12)
Evaluation of self-care	122	108(89)	14(11)
Evaluation of work	122	103(84)	19(16)
Evaluation of play	121	113(93)	8(7)
Assessment of needs	121	115(95)	6(5)
Assessment of strength	121	113(93)	8(7)
Development of treatment plan	122	119(98)	3(2)
Re-evaluation of self-care	122	85(70)	37(30)
Re-evaluation of work	122	75(61)	47(39)
Re-evaluation of play	121	84(70)	37(30)

response (over 80%) for all areas, with the exception of re-evaluation of self-care and play, which had a lower response rate of 70%. The evaluation and re-evaluation of work were also shown to have a lower response by OTRs (84% and 61% respectively). However, frequency rates showed well over 50% of all OTRs fulfill all of these functions on a regular basis.

The ten functions classified as case management functions and responses are summarized in Table 7. When the frequency response rate was over 50% it was assumed that OTRs were performing the functions. Six of the ten case management functions had a frequency response over 50%. The functions included were continuous monitoring of services (98%), advocacy roles (61%), outside of regular treatment therapeutic contact (71%), treatment team contact (99%), contact within acute hospitalization (87%), and crisis intervention (63%). In the acute hospitalization contact, the results were further separated into day treatment (80%) responses and acute care setting (92%) responses because therapists in acute care settings have contact by virtue of their job description. The four functions that had a response rate under 50%, meaning most OTRs were not performing these

Table 7

Identifiable Case Management Functions Performed by OTRs

Functions	(N)	No. (%) yes	no
Continuous monitoring	122	120(98)	2(2)
Set up outside services	122	59(48)	63(52)
Advocacy	121	74(61)	47(39)
Outside Therapeutic Contact	122	87(71)	35(29)
Liaison/Advocate Role	121	55(45)	66(55)
Treatment Team Contact	121	120(99)	1(1)
Home Visits	120	16(13)	104(87)
Treatment in the community	119	39(33)	80(67)
Contact in acute hospital	105	91(87)	14(13)
Crisis intervention	119	75(63)	44(37)

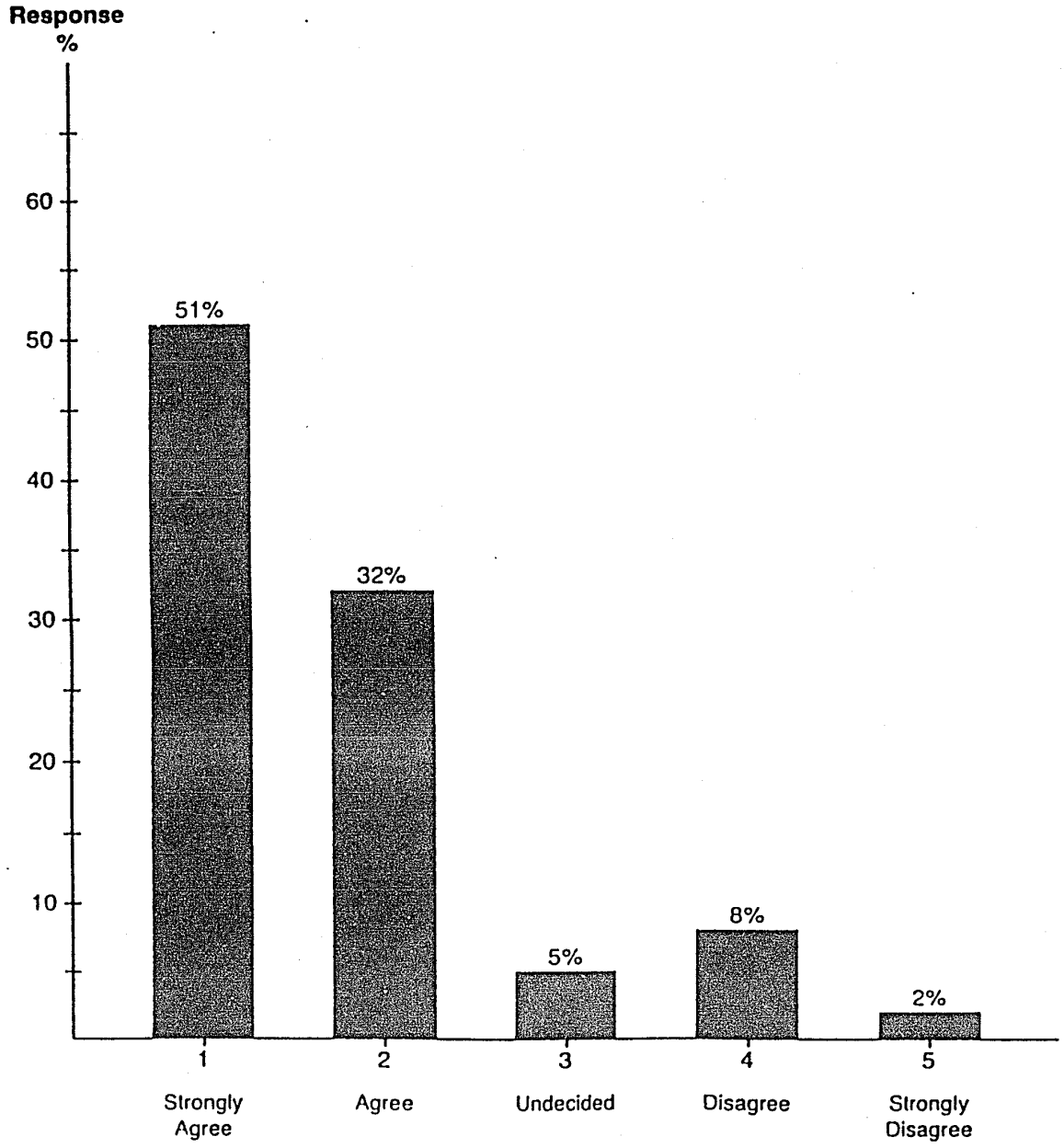
functions, included setup of outside services (48%), liaison and advocate roles (45%), home visits (13%) and treatments in the community (33%).

Perceptions of OTRs as Case Managers

In question number 21, OTRs were asked if OTRs could act as case managers. This question was asked to determine if occupational therapists in community mental health settings perceive themselves as potential case managers. The results are illustrated in Figure 1. Sixty-two or 51% of OTRs working in mental health "strongly agree" that occupational therapists could be potential case managers, and another 39 or 32% "agree" with this statement. Seven or 5% were "undecided", eight percent state they "disagree" and two percent "strongly disagree" with the statement. A total of 101 or 83% of working OTRs responded in favor of occupational therapists performing case management.

As part of question 21, a comment section was included for OTRs to voice opinions about case management in mental health. Respondents who marked "strongly agree" or "agree" generally gave explanations relating to occupational therapists viewing individuals holistically, and considering all aspects of a client's life in

Figure 1. Responses regarding Occupational Therapists as Case Managers.



evaluation and treatment. Many cited occupational therapists as "uniquely qualified" professionals with skills necessary to identify functional levels of clients in everyday living activities that are needed to live in the community. Other comments related to OTRs viewing the individual's strengths and needs and being able to adapt and assist client adjustment into the environment. Also, OTRs observation skills and ongoing assessments of everyday functions were mentioned as ideal for case managers for long term care and follow through in the community. Specific OTRs comments included "not potential, we are case managers" and "many OTRs are functioning in this role of case manager, only without the title."

Therapists who marked "undecided" included the following comments: "no hands on opportunity," "overwhelming paperwork and large case loads," "lower pay scale than OTRs," and "depends on individual qualifications."

Therapists who marked "disagree" or "strongly disagree" cited reasons that case management would be impossible to carry out in an acute care setting due to high case loads, fast turnover of clients, and the difficulty of follow-up after discharge. Several

comments stated that the occupational therapy role should be "specific, task oriented treatment" and case management as "generic general service" or "just organizers of service." One respondent cited the definition of case management as vague and urged a "clearer definition that specifies occupational therapy skills, (not social work's) with a clear statement of expertise." Another suggested that OTRs act in "too many roles, and occupational therapy role needs clarification not dilution." A few suggested that if OTRs were to fill such roles, a master's degree should be required.

Respondents were asked if their facility currently had case managers, and if so, what mental health professional acted in this role? Fifty-eight (49%) stated that they did have case managers in their facility. Out of the 58, nine had OTRs filling the case manager role. Other facilities had mental health professionals from various disciplines, such as social workers, pyschiatric technicians, and registered nurses.

CHAPTER 5

RESULTS, IMPLICATIONS, AND SUMMARY

The purpose of this research was to identify whether services offered by psychiatric OTRs working with chronically mentally ill (CMI) populations would fulfill case management functions, as well as, to explore the attitudes of OTRs about case management and the appropriateness of the case management model for occupational therapy. Current services available for the CMI populations in mental health are fragmented and disjointed. Case management is one option for integrating services and providing a coordinated treatment approach for the individual with chronic mental illness. The philosophy of occupational therapy focuses on treating the "whole" individual in all aspects of his/her life, this is consistent with the functions of case management.

The research questions answered for this study were:
1. How many occupational therapists who practice in community mental health setting with chronically mentally ill populations perform the functions of case managers?

2. Do occupational therapists in community mental health settings perform case management functions and perceive themselves as potential case managers?

3. What services are occupational therapists, who work in community mental health with chronically mentally ill populations, currently offering that are recognizable as case management functions?

4. Does the model of case management, as described in the literature, correspond to the functions performed by occupational therapists who are currently working in community mental health?

Each of these questions is discussed in regard to the information gathered from the questionnaires.

Services and Functions Performed

The results of this study indicate that a number of occupational therapists in mental health perform functions that are associated with case management. Data collected from responses on identified functions, presented in Table 6 and 7, represent areas of practice that occupational therapy and/or case management should perform. Responses presented in Table 6 were functions that involved standard practices of a treatment process in occupational therapy. Functions presented in Table 7 were identified as necessary for case management and

the treatment of the CMI populations. The functions in Table 6 are directly related to the functions in Table 7 because they enable the therapists to be apprised of their clients' current functional level which is representative of the complete treatment process in case management.

In response to the research question of how many OTRs in community mental health perform functions of case management, data indicate that at least 80% perform the following functions: initial interview (107 or 88%), evaluation of self-care (108 or 89%), evaluation of work (103 or 84%), evaluation of play (113 or 93%), assessment of needs (115 or 95%), assessment of strengths (113 or 93%), development of treatment plan (119 or 98%), continuous monitoring (120 or 98%), treatment team contact (120 or99%), and contact in an acute hospitalization (91 or 87%). In addition, at least 60% percent perform the following functions: re-evaluation of self-care (85 or 70%), re-evaluation of work (75 or 61%), and re-evaluation of play (84 or 70%), advocacy (74 or 61%), outside therapeutic contact (87 or 71%) and crisis intervention (75 or 63%). The lower percentages of the last six functions could be due to the fact that most of the respondents who answered the questionnaire worked in acute settings. The rapid turnover rate in

acute hospitals limits the opportunity to re-evaluate patients. By examining each individual case management function, the numbers suggest that a majority of OTRs are performing (16 of 20 functions identified) case management functions.

Perceptions of OTRs about Case Management

The second research question explored whether OTRs in mental health perceived themselves as potential case managers. The data indicate that a majority (83%) of OTRs in mental health agree that occupational therapists are capable of fulfilling the role of case manager. A case manager is one who can identify, orchestrate, and perform those services that the CMI populations need to be successful in the community. Functions and services offered by case managers and occupational therapy have parallels. Repeatedly, respondents cited the basic theoretical philosophy of occupational therapy as reason why OTRs would be suited for the case manager role. One common premise was the view of the client in the entire realm of his/her world (cognitive, social, psychological, physical and sensory/motor aspects of a client's functional skill level). The second premise was that the OTR's focus in treatment is asking what does this client need to be as independent as possible in the least

restrictive environment? Occupational therapy uses the clinical setting or more importantly is able to use the setting in which the client lives for treatment. Treatment then focuses on acquiring skills for everyday life such as organization of chores in the client's home, riding buses, shopping in his/her grocery store, or functioning at the vocational site. The treatment involves problem solving functional issues where the function takes place. OTRs have the skills to continually evaluate their client's capabilities and the knowledge to facilitate means to increase or maintain independence.

One individual who agreed that OTRs could be case managers questioned whether it would be occupational therapy. The literature described a continuum of case management. On one end there is the case manager who provides little or no direct service and is a "broker" of services, and on the other end are the case managers who are clinicians and provide their clients with clinical treatment, teach skills, and enhance judgement. The latter of these is the one the author is proposing that OTRs can fulfill. As the results indicate, many OTRs in mental health are performing the functions of case management in their positions. The identifiable

functions that were not performed by OTRs in mental health are not because of lack of skill, but rather because of restrictions in the work settings.

Many therapists who were "undecided" or "disagreed" with the concept of OTRs filling the role of case managers limited the view of what a case manager would be able to accomplish in an acute care setting. Case management in this setting would be unrealistic because of the client load, the high turnover rate of clients, the short length of stay, and the limited opportunity for follow through. The issue is whether or not OTRs could fulfill the role and is not meant to be limited to a certain treatment setting. However, for the CMI population, the ideal location for a therapist to perform case management would be in the community where the client lives.

Other therapists who "disagree" raised valid points about the lack of a clear definition for case management and occupational therapy. Terms and functions need to be further defined and clarified in the role of case management. For example, clarification would result in more accurate delivery of case management services to the CMI population. Schwartz, Goldman & Churgin (1982) liken the term case management to the Rorschach test, where

individuals or agencies project their own interpretation of what case management should fulfill. Unfortunately, the result is inconsistency in the system and delivery of services.

Identifiable Services Performed

The third research question sought data to identify what services were currently offered by OTRs in mental health that are recognizable case management functions. The data indicate that six of ten functions specifically related to case management were performed by the majority of OTRS (percentages over 60%). These included continuous monitoring, advocacy, outside therapeutic contact, treatment team contact, contact in acute hospitalization, and crisis intervention. The functions which were not being performed included set up of outside services, liaison/advocate role, home visits, and treatment in the community. Each function will further be discussed as it relates to occupational therapy and case management with the CMI populations. As stated in the questionnaire, "**continuous monitoring** of progress towards treatment goals" was identified as a function that OTRs perform 98% (120 of 122) of the time in practice. One may interpret this to encompass only occupational therapy goals. However, there was also a

99% (120 of 121) response for **treatment team contact** function which indicates that OTRs are concerned with immediate occupational therapy goals, as well as other needs or services the client may require from other disciplines. The active role of the OTRs with the treatment team indicates an active role in the entire treatment of the client. Continuous monitoring in case management is the process that is used to ensure that agreed upon services are being delivered to the client. OTRs perform a role in their regular treatment process that is similar to a case monitoring.

The third function, **advocacy**, relates directly to the monitoring process. Advocacy is the process of enlisting support from or for whatever service which is necessary for the client. Sixty-one percent (74 of 121) of the OTRs in mental health who were surveyed performed the function of advocacy. Advocacy was specified in the questionnaire as "on the client's behalf with other service providers." Many respondents (from comment section on question number 10) saw their role as a type of advocacy for the client in the hospital. However, in question number 12, when asked if they performed a **liaison or advocate role** in the community, only 45% (55 of 121) replied "yes." Other contradictions included

only 48% (59 of 122) of respondents stating that they were active in **setting up outside services,** yet 71% (87 of 122) replied "yes" to **outside therapeutic contact.** The major conclusion to be drawn from this is the need for further definition of terms.

Most OTRs in mental health stated advocacy as a function commonly performed. Types of advocacy included consulting with the treatment team, family, or vocational counselors, monitoring changes of medications, planning for discharge and/or referrals for other services. This is certainly an advocacy role; in addition, this role should encompass the day to day contact in the community with the CMI populations in order to advocate for their needs in the environment in which they live.

Home visits and **treatment in the community** are areas in which the CMI population needs therapeutic assistance for their everyday living skills. The majority of OTRs surveyed do not perform these functions (16 or 13% and 39 or 33%, respectively, Table 7). Most respondents cited the constraints of the setting in which they work, not lack of skills, as reasons why they do not provide services in these areas. The treatment setting has an effect on what or how types of treatment are delivered.

Therapists who work in acute care hospitals typically treat individuals during a crisis, or psychotic episode. Their goals are short term, their length of treatment is limited, and follow-up is rare. In contrast, day treatment therapists see clients for an average of nine to twelve months (Table 4). Their goals are long term and deal with clients in their everyday life, not just in a crisis period. Providing supportive community services, not specifically addressed in the data, is another growing area of treatment where OTRs offer services to the CMI. Treatment does not take place at a day treatment center, but instead takes place in the community where the individual lives.

The last two functions, **crisis intervention** and **contact in the event of an acute hospitalization** were performed by the majority of OTRs (91 or 87% and 75 or 63%, respectively). Intervention on this level is common for the OTRs in mental health. In question number 18, OTRs were asked if they "became an active member of the treatment team" if their client required hospitalization. Most respondents who worked in acute care setting answered "yes" (60 or 92%) to contact with the treatment team of which they are a part as their job dictates. The question attempted to elicit responses from OTRs

regarding becoming a member of a treatment team in an acute care hospitalization as fulfillment of the role of case manager. As case manager, the therapist would follow the client into whatever environment was necessary for treatment. This is not merely because the therapist is a part of the regular acute care hospital staff, but because of the case management role. Looking at only the day treatment setting responses, data indicate that 80% of the OTRs fulfill this function by having contact with the acute care hospital treatment team and by becoming active members of that team. Treating the client in whatever environment he/she is in is an important concept in case management, as it provides the continuity and follow through that makes case management a successful treatment approach with the CMI.

The combination of functions discussed previously are common in the case management model. Occupational therapists have the skills to perform these functions, but seem to be limited by the constraints of the work setting and time available for treatment. The nature of chronic mental illness and successful treatment of the CMI population is one where long-term care must be considered in planning treatment goals (Drake & Sederer, 1986).

Models of Case Management

The data collected in this study were taken from the questionnaire developed to explore concepts presented in the literature (Klasson, 1986; Intagliata, 1982) on models of case management for the CMI populations. Klasson (1986) presented a direct service delivery model of case management, where the OTR as a case manager provides clients services to ensure adaptation in the community. Intagliata (1982) did not specifically mention occupational therapy, but described models of case management that would be most effective for community care of the chronically mentally disabled. The data from this study indicate that there are similarities between Klasson's and Intagliata's models, and that OTRs in mental health are actually providing case management services to the CMI population. The assessment, evaluation, development of the treatment plan, continuous monitoring, advocacy, strong involvement with treatment teams are all easily connected to functions that occupational therapists fulfill. However, there are some discrepancies which also need to be discussed.

The largest discrepancy involves the lack of treatment taking place in the home or in the community.

As noted previously, this study predominantly involved OTRs in acute care hospitals. If the Occupational Therapy Association of California members' list is any indication, OTRs tend to work more in medical settings than in the community treatment centers. For the CMI, treatment in the community using a case management model may be the key to successful mental health treatment. Occupational Therapy has the potential to provide a relationship in case management that would be effective for all involved: the CMI population, mental programs, and the occupational therapy profession. The idealized setting of the occupational therapy clinic in an acute care setting can be viewed as a place for the client to learn skills from the therapist, but where the function takes place is where the skill must be practiced. Evaluation of needs and assessment of skills should be performed where the client will use the skills to function in his/her environment.

The second discrepancy relates directly to the limited amount of treatment performed by OTRs in the community and the lack of interaction by therapists with outside community services. The results indicate that OTRs are not practicing in the community and are not making important contacts for referrals in the community

for the client's needs. Occupational therapy offers clients many options, but realistically, one needs the network to provide the full range of services for clients. These services may include counseling or support groups, or simply finding where the client could do his/her laundry. The range of services will depend upon each individual client.

Parallels can be drawn between the case management models in the literature (Klasson, 1986; Intagliata, 1982) and what is occurring in the field of occupational therapy in mental health, but the full picture cannot as yet be constructed. It is complicated by where the jobs and practice of occupational therapy takes place, but certainly not by lack of skill.

Recommendations and Professional Implications

More research needs to be conducted on the subject of case management with the CMI populations. Future research should include a study of what can be identified as successful case management factors with the CMI population. Also, the topic of models of case management needs to be studied. Is one model of case management more effective than another with the CMI population? Functions of case management need to be clarified and defined in the mental health field and in occupational

therapy. Another study should focus on the circumstances that enable OTRs to be effective case managers. Is there a correlation amoung OTRs performing case management functions and demographic and treatment variables? For example, is there a relationship between the advocacy role and years of experience, setting, case load or treatment focus when OTRs are in the case management role. As mentioned previously, a study should encompass only OTRs in community settings working with CMI populations. Research on this topic has many possibilities and many questions yet to be answered.

As the destiny of any profession lies with the professionals who make up the whole, occupational therapists must take an active role in pursuing employment in the community if they are to make a valuable in contributing to the treatment of the CMI populations. A comment from one occupational therapist suggested case management would be just a "burden of another role" for OTRs. This author disagrees and instead sees OTRs as case managers as an exciting, suitable expansion for the profession of occupational therapy. Occupational therapy and case management is a union of roles that is already occurring in the field. The profession must take steps to define and adopt the

model of case management.

Chronic mental illness is a long term health care issue and individuals with CMI will most likely always require some type of intervention. To effectively treat this population one cannot only provide treatment in the acute care hospital during psychotic espisodes, but must continually provide assistance with the issues in their day to day lives in the community.

Addendum

It is to be noted at the time of the literature search and collection of data for this study "chronically mentally ill" was the term used to describe individuals suffering from long-term mental illness in the professional literature. The term currently being used in the literature for these individuals is "seriously mentally ill."

Further, the phrase "long-term health care" has another implication for occupational therapy in that the profession has the opportunity to be active in fulfilling the needs of chronic illness with all populations, whether they have mental or physical disabilities. The researcher's current position as an occupational therapist is in the case manager role with adults who have traumatic brain injuries. It has been fortunate that this research has provided further insight into her role as an occupational therapist-case manager and her professional position has given her first hand experience regarding case management as a workable model for service delivery and has aided in this research.

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APPENDIX A

QUESTIONNAIRE

Questionnaire

Thank you for taking the time to fill out this questionnaire, it is fairly brief and should take less than 20 minutes to answer the questions. This research concerns case management and OTR's working in mental health with individuals who are chronically mentally ill. For this research, the person with chronic mental illness is defined as the psychiatric client with a long history of psychiatric illness, including psychiatric hospitializations. Specific characteristics include high vulnerability to stress, deficiencies in living skills, extreme dependency, difficulty in the competitive job market and difficulty with interpersonal relationships. (Test & Stein, Schizophrenia Bulletin, 4(3), 1978). Unless otherwise specified, please answer the following questions in regards to a client under this definition.

General instructions: Please answer all questions by simply placing a (✓) in the appropriate box; some questions allow space for additional brief comments. Thank you.

General Information:

1. Number of years work experience in mental health as an OTR?

    1. ( ) 1-3 years

    2. ( ) 4-6

    3. ( ) 7-9

    4. ( ) 10+

2. Postion currently held:

    1. ( ) staff occupational therapist

    2. ( ) supervisor/senior occupational therapist

    3. ( ) consultant

    4. ( ) other, please specify_____

3. Is your position:

   1. ( ) full time
   2. ( ) 3/4 time
   3. ( ) 1/2 time
   4. ( ) other (please specify)_____

4. Check all of the following that pertain to your practice.

   1. ( ) community setting
   2. ( ) day treatment
   3. ( ) acute hospital
   4. ( ) long term setting
   5. ( ) other, please specify_____

5. What is your current total client case load?

   1. ( ) 0-5 clients
   2. ( ) 6-10
   3. ( ) 11-15
   4. ( ) 16-20
   5. ( ) 21 and over

6. How many total number of clients have you treated over the past year?

   1. ( ) 0-50
   2. ( ) 51-100
   3. ( ) 101-150
   4. ( ) 151-200
   5. ( ) 201 +

7. According to the definition of chronically mentally ill listed above, what percentage of the population that you treat would be considered in this category?

1. ( ) 0-25%
2. ( ) 26-50
3. ( ) 51-75
4. ( ) 75-100

8. What is the average length of treatment for the chronically mentally ill client that you see?

1. ( ) less than 1 month
2. ( ) 1-3 months
3. ( ) 4-6 months
4. ( ) 7-9 months
5. ( ) 10-12 months
6. ( ) over 12 months

9. What is the average number of times per week your clients receive occupational therapy services?

1. ( ) 1 time(s)
2. ( ) 2
3. ( ) 3
4. ( ) 4
5. ( ) 5 or greater.

10. Please answer yes or no for all areas that apply tc your treatment with your clients.

Initial Interview		1. ( ) yes 2. ( ) no
Evaluation of:	self care	1. ( ) yes 2. ( ) no
	work	1. ( ) yes 2. ( ) no
	play/leisure	1. ( ) yes 2. ( ) no
Assessment of:	needs	1. ( ) yes 2. ( ) no
	strengths	1. ( ) yes 2. ( ) no
Development of treatment plan		1. ( ) yes 2. ( ) no
Continuous monitoring of progress towards treatment goals		1. ( ) yes 2. ( ) no
Arranging for services outside your treatment area		1. ( ) yes 2. ( ) no

If yes, please indicate services arranged_____

Re-evaluation of:	self care	1. ( ) yes 2. ( ) no
	work	1. ( ) yes 2. ( ) no
	play/leisure	1. ( ) yes 2. ( ) no
Advocacy on the client's behalf with other service providers		1. ( ) yes 2. ( ) no

If yes, please give examples_____

11. Do you have any other therapeutic contact with your client outside of the regular occupational therapy treatment session?

1. ( ) yes If yes, how often?_____
   If yes, in what way?_____
2. ( ) no

12. Do you ever act as a liaison or an advocate for services for your client in the community?

1. ( ) yes
2. ( ) no

13. If yes to # 12, to what extent do you act as a liaison or advocate?

1. ( ) less than one time a week
2. ( ) 1 time (s) a week
3. ( ) 2
4. ( ) 3
5. ( ) 4 or more

14. Are you in contact regularly (one to two times a week) with other members of your client's treatment team?

1. ( ) yes
2. ( ) no
3. ( ) NA

15. Please rank order the areas in your practice that you primarily focus upon with your clients. Rate these from 1 to 8 according to your practice. (*1 being the highest, 8 is the lowest)

1. ___ Activities of daily living (cooking, cleaning, money management, time management, transportation)
2. ___ Self-care (hygiene, grooming, body awareness)
3. ___ Social skills (communication, behaviors)
4. ___ Leisure skills (interests, hobbies)
5. ___ Vocational (work tasks, skills training)
6. ___ Psychodynamic/Psychotherapeutic activities (projective techniques, insight, reduction of symptomology)
7. ___ Cognitive skills (attention, concentration, problem solving, following directions)
8. ___ Sensory motor (sensory awareness, body awareness, activity levels, physical stimulation)

16. Are you able to incorporate home visits into your treatment program?

1. ( ) yes
2. ( ) no

17. Do you use the community setting for actual training of skills in your client's home environment?

1. ( ) yes
2. ( ) no

18. If your client requires acute psychiatric hospitalization, are you in contact with the client's treatment team within the hospital?

1. ( ) yes

2. ( ) no

19. If yes to #18 are you an active member of the treatment team in the hospital?

1. ( ) yes

2. ( ) no

20. Are you involved in crisis intervention with your client at any time?

1. ( ) yes If yes, please give an example._____

2. ( ) no

21. Generally in health care, <u>case management</u> has a common process or method that ensures consumers are provided with whatever services they need in a coordinated, effective, and efficient manner. A <u>case manager</u> is the individual who monitors the needs of clients, facilitates treatment, provides services, and fulfills case management functions. Would you consider occupational therapists as potential case managers?

1. ( ) Strongly agree

2. ( ) Agree

3. ( ) Undecided

4. ( ) Disagree

5. ( ) Strongly Disagree

Why? (Please be specific)

22. Is there currently a case manager position in your facility?

1. ( ) yes If yes, what is his/her speciality area

2. ( ) no

Thank you for your time! If you would like to see the results of this study please return the enclosed card.

APPENDIX B

COVER LETTER

SJSU SAN JOSE STATE UNIVERSITY

A campus of The California State University

School of Applied Arts and Sciences • *Department of Occupational Therapy*
One Washington Square • San Jose, California 95192-0059 • 408/924-3070

Dear Occupational Therapist,

You have been selected to participate in a study of psychiatric occupational therapists working with the chronically mentally ill populations. The purpose of this study is to gain information about the contribution that occupational therapy practice offers this population. The results of this study will be used as the basis of a thesis in partial fulfillment of the requirements of a Masters Degree at San Jose State University in occupational therapy.

All information gathered will remain confidential and neither your name nor the facility's will be used for any purpose. Please feel free to add comments on the questionnaire concerning any thoughts or questions. Please return the questionnaire within two weeks (6-6-88) in the enclosed self-addressed, stamped envelope. If you are interested in the results of this study please return the enclosed request card. By completing the survey you are giving your consent for the data to be used in presentations and published reports concerning the results of the questionnaire. Thank you for your participation.

If you have any questions or complaints about the questionnaire, I can be reached at 408/842-2283 or Dr. Elayne Klasson may be addressed at 408/924-3070. For questions or complaints about research subject's rights, or in the event of research - related injury, contact Serena Stanford, Ph.D (Associate Academic Vice President for Graduate Studies) at 408/924/2480.

Sincerely,

Eileen Maddox, M.S. Candidate

APPENDIX C

POST CARD

DEAR OCCUPATIONAL THERAPIST:

Recently you received a questionnaire in the mail concerning occupational therapy and mental health. This card is a reminder to please fill out and return the questionnaire. Research is vital to our profession, please put that questionnaire in the mail today!!

Please disregard this notice if you have already returned the questionnaire. THANK YOU!

Eileen Maddox OTR